SECTION 9000

9000 CHILD HEALTH INSURANCE PROGRAM (CUB CARE)

9000.01SCOPE

The Cub Care Program is available to individuals who are under the age of 19 who are ineligible for Medicaid and who meet certain other requirements as identified in this section. Coverage is available as of August 1, 1998.

The Department has the right to collect from other available insurance or from settlement(s) for accidents or injuries whenever the Medical ID was used.

9000.02BASIC ELIGIBILITY REQUIREMENTS

To be eligible for Cub Care, individuals must meet the basic eligibility requirements for getting full Medicaid coverage as identified in Section 1200 regarding residency and citizenship. Social Security numbers are not required for Cub Care coverage. There is no requirement to refer to Support Enforcement the non-custodial parent without health insurance for the children applying for Cub Care.

I. Penalty for Nonpayment of a Premium

Cub Care will not provide coverage to children living in a household where a premium was not paid when due.

For each month there is such an unpaid premium, there is a month of ineligibility up to a maximum of three (3) months.

The penalty period begins in the first month following the enrollment period in which the premium was overdue.

> For example: Children were covered from November, 2001 through October, 2002 and no premium was paid for the entire twelve (12) months. The children cannot receive Cub Care coverage forNovember, December, 2002 and January 2003.

If the child is eligible for Medicaid during the penalty period under Cub Care, Medicaid coverage will be provided. The period of ineligibility for Cub Care will run concurrently with a period of eligibility for Medicaid.

9000.02 cont.

There will be no period of ineligibility if there is a "good cause" for nonpayment as described in 9000.11 or if the premium is paid during the "grace" period.

II. Children Excluded from Coverage:

A. A child who is eligible for coverage under the Medicaid program. This includes coverage under Transitional Medicaid (TM). If the individual chooses not to pay a premium due for TM, the family is considered ineligible for Medicaid and the children under age 19 will be potentially eligible for Cub Care.

B. A child age 19 and over.

C. A child residing in a public institution or an inpatient psychiatric facility.

A public institution is one in which the facility is under the administrative control of the State or Federal government. An example is AMHI, BMHI, the Maine State Prison, or the Maine Youth Center.

A child who is residing in an inpatient psychiatric facility is not eligible for Cub Care. An inpatient psychiatric facility includes AMHI, BMHI, Arcadia and JBI. If a child is an inpatient in a psychiatric unit of a general medical hospital, the child is potentially eligible for Cub Care.

D. A child who is eligible for coverage under the State Employee Health Insurance program through a relative with whom they are residing. Individuals covered under the State Employee Health Insurance program are employees for:

1. the Executive, Judicial, and Legislative branches;
2. the Maine Turnpike Authority;
3. Maine Maritime Academy;
4. the Retirement System;
5. the Maine Blueberry Commission in Orono;
6. the Maine Potato Board in Presque Isle;
7. the Maine Dairy Council in Augusta;
8. the Maine Sardine Council in Winterport
9. employees of AFSME Council 93 in Augusta;

9000.02 cont.

10. employees of MSEA, State Street, Augusta; and
11. employees, including teachers, of the Technical Colleges.

The Technical Colleges are as follows:

a. Northern Maine Technical College in Presque Isle;
b. Washington County Technical College in Calais;
c. Eastern Maine Technical College in Bangor;
d. Kennebec Valley Technical College in Fairfield;
e. Central Maine Technical College in Auburn;
f. Southern Maine Technical College in South Portland; and
g. York County Technical College in Wells.

E. A child who is covered under a group health insurance plan through an employer or under health insurance as defined by the Health Insurance Portability and Administrative Act (HIPAA). This includes most insurance plans except for those covering one particular service or illness only, such as insurance for dental care or cancer.

This exclusion applies regardless of whether the coverage is provided through an adult who resides with the child or through an adult living in another household.

9000.02 cont.

III Children with a Three (3) Month Waiting Period

With certain exceptions noted below, there is a three (3) month waiting period before a child can be covered by Cub Care if that child is dropped from health insurance provided through an employer.

For example, if the insurance ends January 10, Cub Care cannot start until May.

There is no three (3) month waiting period if any of the following exists:

A. The individual who dropped the coverage does not reside with the child.

B. The family (employee) pays 50% or more of the cost of the child's coverage.

For example, if the monthly cost of the child's coverage is $100 and the family pays $65, the family is considered to be paying 50% or more of the cost of the child's coverage.

C. The family pays over 10% of all family income for family coverage (including the child dropped from coverage).

Family income is defined as the total gross non-excluded income of: the child, the child's siblings and step-siblings under age 21 with whom they reside, the adult dropping the coverage and their spouse with whom whey reside.

Income includes both earned and unearned income.

D. The individual had good cause for terminating the insurance coverage.

Good cause exists when the individual can substantiate that the coverage was dropped for a reason other than to be covered by Cub Care. Some examples are: The adult lost coverage for the child because of a change in employment, termination of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or termination for a reason not in the control of the employee.

Reminder: There is no three (3) month waiting period if a child is dropped from an individual health insurance plan (not provided through employer).

9000.03APPLICATION PROCESS

I. An application is the request for medical coverage made by signing and dating the Agency's application form. The individual or anyone acting on the individual's behalf may sign the application form. The applicant may choose anyone to help in completing the form.

The date of application is the date the signed application form is received in any regional office. Applications must be processed within 45 days of their receipt by the Agency. If the applicant is not sent a notice of the eligibility decision within 45 days, temporary coverage will be authorized as identified in Section 1431.

All signed applications will be acknowledged in writing. A written decision of eligibility will be sent to the applicant.

An application is valid for authorizing coverage as of the month the application is received or the following month.

II. When an individual applies for medical coverage, this is considered to be an application for Medicaid and Cub Care.

9000.04CLIENT AND AGENCY RESPONSIBILITIES

I. Verification of Eligibility Factors

Verification of information needed to determine eligibility must be requested initially from the individual. If information is requested from other sources (with the exception of public records) the individual must be informed. If collateral contacts are necessary and the individual does not give consent, denial or termination must occur.

When a decision cannot be made due to inconclusive or conflicting information, the individual will be notified what questions remain and what needs to be resolved. If the Department cannot determine that eligibility exists after contacting the individual or collateral contacts, assistance will be denied or terminated.

II. Notice of Eligibility or Ineligibility

Individuals will be notified in writing as soon as eligibility is determined. If some of the individuals applying for medical coverage are eligible and some are not, the notice must specify who is or is not eligible and the reasons for each individual's ineligibility.

Individuals whose eligibility begins after the month of application must be sent a denial notice for the months of ineligibility.

When an individual is determined to be ineligible, the notification will contain:

A. a statement that the application has been denied;

B. the specific reason(s) for the denial;

C. the manual citations which support the decisions; and

D. an explanation of the individual's right to request a Fair Hearing;

III. Financial Eligibility

Financial Eligibility is projected over a twelve (12) month basis, starting with the month of application or the following month. The child remains continuously eligible for this twelve-month period. Premiums are set at the beginning of the twelve-month enrollment period and do not change regardless of income. Any income changes must be reported when the child reapplies for coverage.

Changes affecting eligibility must be reported within ten (10) days of their occurrence. Examples of such changes include: an eligible child

no longer resides in the household, or s/he is covered by health insurance. "Occurrence" is the date the change takes place.

The individual may withdraw from Cub Care and end his/her twelve-month enrollment period if s/he becomes Medicaid eligible. See "Changes":

9000.09.

IV. Adverse Action

In situations when the intended action is to discontinue eligibility or to reduce services, timely and adequate notice must be given to the recipient. However, coverage will not be continued beyond the enrollment period pending a Fair Hearing decision. Also, as long as a child is open for Cub Care coverage, a premium will be due and unpaid premiums will incur a penalty.

"Timely" means that the notice must be mailed 12 days before the intended change would be effective (10 days for notice plus 2 days for mail).

"Adequate" means a written notice which includes a statement of:

A. the action the Department intends to take;

B. the reasons for the intended action;

C. the regulations supporting such action; and

D. an explanation of the rights to request a Fair Hearing;

1. *Denials*. If a child is not eligible for Medicaid but eligible for coverage under Cub Care, s/he needs to be informed of his/her eligibility for Cub Care, and that Medicaid has been denied.

   If an application is denied for Family-Related Medicaid and Cub Care, notification will be given that other coverage may be available if the household has large medical bills or a child has a disabling condition.

2. *Closings*. If coverage under Cub Care is ended for a reason other than the enrollment period has ended, the individual will be given adequate and timely notice. When the child is granted coverage for the twelve-month period, s/he will be informed that coverage will automatically end at the end of the twelve-month period.

3. *Hearings*. Rules regarding Fair Hearings are identified in Sections 1180 and 1181 except as they differ for Cub Care as identified in the 9000 chapter (section). A Fair Hearing may be requested for an adverse action taken during the enrollment period, but benefits will not be continued beyond the enrollment period pending the Fair Hearing decision. For coverage to continue beyond the enrollment period, the individual must file a reapplication and be found eligible without a penalty. If for some reason a household's premium is increased during the enrollment period due to adding a child to Cub Care and the increase is appealed, the increased fee will be effective when the child is added to Cub Care coverage pending the Hearing decision. The household's increased premium is due in accordance with the policies of this section and any unpaid premium is subject to a penalty of ineligibility.

   If a household appeals a penalty period being imposed at the time of reapplication, the penalty will be imposed pending the Fair Hearing decision.

   If the Fair Hearing decision reverses the Agency action, any penalty imposed will be lifted and any increased premiums that have been paid will be returned to the household.

9000.05ELIGIBILITY PERIODS

I. Coverage under Cub Care is determined for a twelve-month enrollment period for all members of a household, beginning with the month of application or, if ineligible for that month, coverage starts in the following month. There is only one enrollment period for a household. A household is composed of people residing together among whom there is a financial responsibility.

II. Eligibility is determined for a twelve-month period by projecting income over that twelve-month period, including the month of application. The child remains eligible for the twelve-month period without regard to changes in income.

   In some instances, the individual is not eligible for coverage during the month of application but is eligible for the following month. In this situation, the twelve-month eligibility period begins with the month following the month of application.

III. Reapplications

   The individual must reapply and be found eligible in order for coverage to continue beyond a twelve-month enrollment period.

The individual will be sent a reapplication before the twelve-month enrollment period ends. In order for coverage to continue for the next twelve (12) months, premiums that have been due must be paid, the child must be otherwise eligible, and there are no penalties in effect.

If, by the 15th of the last (12th) enrollment month, a completed reapplication and all needed documentation is received by the Agency, coverage can continue uninterrupted as long as there is financial eligibility and premiums that were due have been paid.

IV. A child who has been covered by Cub Care and whose income exceeds 200% of the federal poverty level at the end of the twelve-month enrollment period will be referred to the Bureau of Medical Services for possible Extended Coverage. (Full Purchase Option (aka Health Insurance Purchase Option {HIPO})

9000.06ASSETS

There is no asset criteria for eligibility under Cub Care.

9000.07INCOME

Income must be equal to or less than 200% of the Federal Poverty Level for the appropriate assistance unit size.

9000.08BUDGETING

I. In determining the appropriate assistance unit size and whose income will be budgeted, the rules of Medicaid will be followed as identified in Sections 1120 (Assistance Units), 2020 (Financial Responsibility of Relatives); 2420 (Special Budgeting Procedures).

II. Determination of countable income

A. Income excluded by Family-Related Medicaid will also be excluded under Cub Care.

B. Gross non-excluded monthly income will be used in the determination of eligibility and in determining the amount of the premium. There are no deductions from income.

9000.08 cont.

C. Income is projected over a twelve-month eligibility period.

D. Medicaid rules are used in anticipating income and in the treatment of irregular, fluctuating, contract, seasonal, and self-employment income, as well as income in-kind, vendor payments and outside contributions.

9000.09CHANGES

I. The child remains eligible for Cub Care throughout the twelve-month period without regard to changes in income. However, coverage can be ended if the child no longer meets any of the other eligibility requirements identified under "basic eligibility requirements."

II. The child must be moved to Medicaid coverage if s/he withdraws from Cub Care and the child becomes Medicaid eligible due to a change in circumstances and the change is expected to last for a full calendar month. The change to Medicaid will be made effective the month the change occurred as long as this change is reported within ten (10) days of its occurrence; otherwise, it is effective the month the change is reported.

If the family withdraws from Cub Care, this will end the twelve-month enrollment period. If coverage continues under Cub Care or Medicaid, this starts 12 months of continuous Medicaid coverage.

III. A child can be added to Cub Care when some members of the household are already covered by Cub Care. For example:

* the child moves into a household;
* the child becomes ineligible for Medicaid.

When a child is added, the premium will be based on the household income already established for the current enrollment period.

Household income will not be reestablished even if the child being added has income of their own.

The child can be added effective the month the change occurred as long as the change is reported within ten (10) days of its occurrence; otherwise, the child is added effective the month the change is reported.

9000.09 cont.

A premium is due for each month a child is open for Cub Care coverage unless exempted from payment.

IV. When a child is covered by Medicaid and becomes ineligible, coverage will be reviewed for Cub Care. A ten-day notice will be given when a child moves from Medicaid to Cub Care coverage.

9000.10PREMIUMS

I. General

Except for Alaska Natives and Native American Indians who are members of a Federally recognized Tribe, individuals who are eligible for Cub Care must pay a premium. Chart VIII identifies the amount of the premium that is due based on income and the number of children covered under Cub Care.

The premium for the twelve-month enrollment period does not change except to reflect the number of children being covered.

Any change in premium is effective the month the child's coverage begins or ends.

II. Coverage for the Current Enrollment Period

A. Premiums are due on the first day of each month for coverage for that month. When a premium is not paid by the first of the month in which it is due, the Department will give notice of non-payment.

NOTE: Notice will also be given at the beginning of the twelfth (12th) month of the twelve-month enrollment period for any premiums that are still unpaid.

B. There is a grace period for non-payment of premiums. For the first through the eleventh (1-11) months of the twelve-month enrollment period, the grace period extends through the last day of the twelve-month enrollment period.

The individual will also be notified that coverage will end at the end of the twelfth (12^{th}) month without further notice if a re-application is not received.

9000.10 cont.

For example, if the enrollment period is November, 2001 through October, 2002, the individual has until October 31, 2002 to pay his/her premiums for month one through eleven (1-11).

The grace period for payment of the premium due in the twelfth (12th) month is the 15th of month number thirteen (13).

For example, if the twelve-month enrollment period is November, 2001 to October, 2002, the individual has until November 15th, 2002 to pay his/her premium for month twelve (12).

If the first (1st) or the 15th fall on a weekend or holiday, the premium is then due on the next workday.

9000.11NONPAYMENT OF PREMIUMS

I. Following a current enrollment period, there may be a period of ineligibility because premiums have not been paid or not paid when they are due. Pemiums are due on the first (1st) day of every month.

II. At the beginning of the last (12th) month of the enrollment period, notification will be given if any premiums for the enrollment period have not been paid when due. The individual will also be notified of the penalty incurred because of the nonpayment.

The penalty will be lifted if the payment is subsequently received by the Agency within the grace period.

III. Premiums can be paid monthly, for more than one month at a time, or they can be paid in advance for the twelve-month enrollment period. Payments will be credited to the earliest months of coverage first, during the current enrollment period.

For example, a monthly premium of $5 is due during a twelve-month enrollment period from January to December and the first payment for $25 is received on June 1st. Months one through five (1-5) will be credited with a premium paid. The June payment is overdue.

IV. There is a month of ineligibility for each month a premium was due, coverage was received, and a premium payment was not made when due.

The maximum period of ineligibility is three (3) months.

The penalty periods start in the first month following the end of the enrollment period in which the premium was due.

For example, if no premiums are paid for the twelve-month enrollment period of January 2002 through December 2002, the child is ineligible for Cub Care for the months ofJanuary, February and March, 2003.

V. If the twelve-month enrollment period is shortened due to a withdrawal from Cub Care, a penalty will be imposed for each month Cub Care coverage was received and a premium was due and was not paid by the end of the enrollment period.

9000.11 cont.

For example, an enrollment period of July through December ends on August 31st due to a withdrawal from the program. If the premiums due for July and August have not been paid by August 31st there will be a penalty period of two (2) months, starting on September 1st when the individual is not eligible for Cub Care.

VI. Any penalty under Cub Care will run concurrently with Medicaid coverage. For example, if a child is denied coverage under Cub Care due to nonpayment of a fee for July and August, but the child is eligible for Medicaid during those months, Medicaid would be granted. The child is then potentially eligible for Cub Care in September.

If a child under penalty due to nonpayment of a fee reapplies and is found to be otherwise eligible for Cub Care, the penalty period will be imposed for up to the first three (3) months following the end of the enrollment period in which the premium was due. Coverage will be granted for the remaining months.

For example, during a January to June enrollment period, no premiums were paid. A reapplication is filed and the children are financially eligible. July, August, and September are penalty months and eligibility exists for October, November, and December.

VII. If a child moves from a household where a penalty has been imposed for nonpayment of a fee to a household where there is no penalty, the child is potentially eligible for Cub Care.

The penalty stays with the adults responsible for the premium payment

VIII. Good cause for nonpayment exists and no penalty is imposed if premiums are not paid or not paid when due because of the following reasons:

A. mail delay;

B. illness of the child’s responsible relative; or

C. unanticipated emergency beyond the control of the responsible relative.

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9000.12 REFUNDS

A refund is due if:

I. a premium has been paid due to agency error,

II. a payment is received after the grace period. This payment, at the option of the family, will be:

A. refunded to the family,

B. credited to past due premiums, or

C. credited to future premiums due.